MDR Tracking Number: M5-04-2057-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 03-09-04

The IRO reviewed therapeutic exercises, office visits, joint mobilization, myofascial release, manual traction, range of motion measurements, special reports, physical performance testing (muscle testing), muscle testing, neuromuscular reeducation and unlisted procedure rendered from 05-01-03 through 09-15-03 that were denied based upon "U".

The IRO determined that the therapeutic exercises, office visits, joint mobilization, myofascial release, manual traction, range of motion measurements, special reports, physical performance testing (muscle testing), muscle testing, neuromuscular reeducation and unlisted procedure from 05-01-03 through 06-28-03 **were** medically necessary. The IRO also determined that the therapeutic exercises, office visits, joint mobilization, myofascial release, manual traction, range of motion measurements, special reports, physical performance testing (muscle testing), muscle testing and neuromuscular reeducation from 07-15-03 through 09-15-03 **were not** medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 06-02-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 97110 dates of service 05-14-03 and 05-15-03 (4 units) denied with denial code "F" (fee guideline MAR reduction). Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper

documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement not recommended

CPT code 95851 date of service 07-28-03 denied with denial code "G" (global). The carrier did not specify which service CPT code 95851 was global to per Rule 133.304(c). Reimbursement is recommended in the amount of $36.00 per the 1996 Medical Fee Guideline.

HCPCS code A4558 date of service 08-26-03 denied with denial code "G" (global). The carrier did not specify which service HCPCS code A4558 was global to per Rule 134.202(a)(4). Reimbursement is recommended in the amount of $5.76 per Medical Fee Guideline effective 08-01-03.

CPT code 99213 date of service 09-05-03 denied with denial code Y/12 (provider billed for service on same day as a physical therapy). Reimbursement per the Medical Fee Guideline effective 08-01-03 is $66.19 ($52.95 X 125%). However, the requestor billed for $62.81 and therefore is the recommended reimbursement.

CPT code 99080-73 date of service 09-15-03 denied with denial code "F" (fee guideline MAR reduction). The respondent made no payment. Per Rule 133.106(f) reimbursement is recommended in the amount of $15.00.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) and in accordance with Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 05-01-03 through 09-15-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Findings and Decision and Order are hereby issued this 16th day of November 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

Enclosure: IRO Decision

November 3, 2004

Ms. Rosalinda Lopez
Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

NOTICE OF INDEPENDENT REVIEW DECISION
Amended Determination

RE: MDR Tracking #: M5-04-2057-01
TWCC #:
Injured Employee:
Requestor: Main Rehab and Diagnostic
Respondent: Texas Mutual Ins. Co.
MAXIMUS Case #: TW04-0165

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the MAXIMUS external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The MAXIMUS chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 40 year-old male who sustained a work related injury on ___. The patient reported that while at work he injured his neck and upper back after lifting an object weighing in excess of 100 pounds. X-Rays of the cervical spine indicated degenerative changes at the C6-7 level. A MRI performed on 4/11/03 showed an annular 3mm bulge at C3-4, and a right C3 neural canal stenosis from a 3mm disc protrusion. The patient underwent an EMG that was reported to have shown left carpal tunnel syndrome. Treatment for this patient's condition has included physical therapy, epidural steroid injections, and oral medications.

Requested Services

Therapeutic exercises, office visits, joint mobilization, myofascial release, manual traction, range of motion measurements, special reports, physical performance testing (muscle testing), muscle testing, neuromuscular reeducation, and 95999-WP (unlisted procedure) from 5/1/03 through 9/15/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Letter 3/4/04
2. Radiology review 9/25/03
3. History and Physical 9/25/03
4. MRI report 4/11/03
5. SOAP notes 5/1/03 – 9/15/03

Documents Submitted by Respondent:

1. No Documents Submitted

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a 40 year-old male who sustained a work related injury to his neck and upper back on ___. The MAXIMUS chiropractor reviewer also noted that the patient underwent an MRI of the cervical spine on 4/11/03 showed an annular 3mm bulge at C3-4, and a right C3 neural canal stenosis from a 3mm disc protrusion. The MAXIMUS chiropractor reviewer further noted that treatment for this patient's condition has included physical therapy that consisted of therapeutic exercises, joint mobilization, myorascial release, manual traction, neuromuscular reeducation, epidural steroid injections, and oral medications. The MAXIMUS chiropractor reviewer indicated that the patient underwent 3 months of care from the time of injury without documented objective and subjective improvement. The MAXIMUS chiropractor reviewer explained that this patient's pain level did not improve with treatment rendered. The MAXIMUS chiropractor reviewer noted that the patient reported that the physical therapy treatments and epidural steroid injections were not helping him. The MAXIMUS chiropractor reviewer explained that the average treatment time is 4-5 weeks for non-complicated cases. However, the MAXIMUS chiropractor also explained that this patient sustained a disc bulge requiring 3 months of treatment. The MAXIMUS chiropractor reviewer noted that after 6/03 there is no documented improvement in this patient's condition. The MAXIMUS chiropractor reviewer explained that this patient's disc bulge is located at the C3-4 level indicating more of a shoulder innervation. The MAXIMUS chiropractor reviewer also explained that this patient's foraminal encroachment is right sided, however the patient's pain is reported on the left side. The MAXIMUS chiropractor reviewer further explained that these findings indicate that the patient was not benefiting from the treatment and should have been discontinued. Therefore, the MAXIMUS chiropractor consultant concluded that the therapeutic

exercises, office visits, joint mobilization, myofascial release, manual traction, range of motion measurements, special reports, physical performance testing (muscle testing), muscle testing, neuromuscular reeducation, and CPT 95999-WP (unlisted procedure) from 5/1/03 through 6/28/03 were medically necessary to treat this patient's condition. However, the MAXIMUS chiropractor consultant also concluded that the therapeutic exercises, office visits, joint mobilization, myofascial release, manual traction, range of motion measurements, special reports, physical performance testing (muscle testing), muscle testing, and neuromuscular reeducation from 7/15/03 through 9/15/03 were not medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department